Central
Bedfordshire
Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

TO EACH MEMBER OF THE
SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

08 May 2014

Dear Councillor

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE - Monday 12 May 2014

Further to the Agenda and papers for the above meeting, previously circulated, please find attached the appendices to the Better Care Fund Report that were not included in the Agenda pack.

13. Appendix 1: Better Care Fund Part 2 Final Submission

Appendix 2: CBC Better Care Fund Plan Final Submission

Should you have any queries regarding the above please contact the Overview and Scrutiny Team on Tel: 0300 300 4196.

Yours sincerely

Paula Everitt
Scrutiny Policy Adviser
email: paula.everitt@centralbedfordshire.gov.uk

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This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

The three tabs containing tables have been protected so that the structure can not be modified in a way that will impede the collation of all HWB plans. However, for the finance tables whole rows can still be inserted by right clicking on the row number to the left of the sheet and clicking 'insert'.

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1. Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Central Bedfordshire Council		£ 3,821	£ 1,190	£ 4,607
CCG #1		£ -	£ 14,100	£ 14,100
BCF Total		**£ 3,821**	**£ 15,290**	**£ 18,707**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Our submission is based on initial modelling work to understnd the potential impact of our Better Care Fund Plan, which is based on four programmes related to key points on the care pathway, from prevention and early intervention to ongoing support to main independence and to reduce reliance on institutional forms of care. Our modelling shows the best case scenario testing, developed within the time available and as such we will continue to test our assumptions as more detailed programme plans which will include further modelling and analysis emerge. Though the governance framework set out in Part One, we will continually monitor the BCF programme and through a performance management framework the joint accountable body for the Fund will receive real time data and regular updates on impact. The Health and Wellbeing Board will also be inv olved in this process. Through these processes we will manage risks and make adjustments as required. For both the CCG and the Council , the focus will be on intermediate care, rehabilitation and reablement; the role and impact of community health services, alignment with the programme of neighbouring authorities and continuing to look at efficiences, process redesign and procurement savings. We will continue to monitor the performance of the pooled budget ensuring that governance and accountability is strong. The Clinical Commissioning Group has agreed to top up the adjustment to reflect the initial sum of £15.290m. Underpinning all this is a continuing communications and engagement programme that covers both health and social care providers as well as key stakeholders in our four localities. Both the Clinical Commissioning Group and the Council are aligning this planning with the current contracting round.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	7.49	7.74
	Maximum support needed for other services (if targets not achieved)	14.37	14.85
Outcome 2	Planned savings (if targets fully achieved)	4.50	4.65
	Maximum support needed for other services (if targets not achieved)	8.63	8.92

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
Reshaping our prevention and early intervention model	Council and Primary Care (in partnership with others including the voluntary and community sector)	£ 287,000		£ 610,000		£ 410,000		£ 2,340,000	
Supporting people with long term conditions through multi-disciplinary working	Community Health Services and Primary Care (in partnership with Council)	£ 300,000	£ 50,000	£ 320,000		£ 300,000	£ 56,000	£ 1,220,000	
Expanding the range of services which support older people with frailty and disabilities	Central Bedfordshire Council (in partnership with others including housing providers and the voluntary and community sector)	£ 867,000		£ 1,170,000		£ 3,989,000		£ 4,500,000	
Restructuring urgent care pathways	Acute Trusts and Primary Care in conjunction with the Council	£ 2,317,000		£ 1,950,000		£ 13,952,000		£ 7,490,000	
Total		£ 3,771,000	£ 50,000	£ 4,050,000	£ -	£ 18,651,000	£ 56,000	£ 15,550,000	£ -

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Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

1) Permanent admissions of older people (65+) to residential and nursing care homes, per 100,000 population
OUTCOME - reducing inappropriate admissions of older people (65+) into residential and nursing care, by reviewing the provisions of community based services and the expansion of the extra care market in Central Bedfordshire, as a alternative to residential care.
MONITORING - this metric will be monitored on a monthly basis, splitting the data by accommodation type and locality area.
2) Proportion of older people (65+) still at home 91 days after discharge from hospital into reablement/rehabilitation services
OUTCOME - to increase the likelihood of people remaining at home following the successful completion of reablement or rehabilitation.
MONITORING - For the Council's Reablement service, this metric will be monitored on a monthly basis, by locality area. Discussions will take place regarding the frequency of monitoring for commissioned services.
3) Delayed transfers of care from hospital per 100,000 population
OUTCOME - effective joint working of hospital services (acute, mental health, and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults, by acting on the common causes for delayed discharges.
MONITORING - this metric will be monitored on a monthly basis, using the SITREP data. Data will be reported at a locality level, based on the hospital location.
4) Avoidable emergency admissions
OUTCOME - reduced emergency admissions, which can be influenced by effective collaboration across the health and care system
MONITORING - Further exploratory work is required to identify availability of the data.
The BCF target of 12% reduction in avoidable emergency admissions has been retained from the Initial submission to align with the CCG's Strategic Plan target.
5) Patient/service user experience
OUTCOME - To demonstrate that patient/service user and carer feedback has been collated and used to improve patient experience and to provide assurance that there is a co-design approach to service design, delivery, and monitoring, putting patients in control and ensuring parity of esteem. Central Bedforshire will use the national measure
MONITORING - whilst awaiting the national metric, Central Bedfordshire will monitor patient experience thorugh the Family and Friends Test and the Adult Social Care Survey. The national metric will be used to monitor performance, once the definitions are published.
6) LOCAL INDICATOR - Injuries due to falls in people aged 65 and over
OUTCOME - To reduce the number of admissions to hospital following a fall, by the increased use of interventions
MONITORING - Further exploratory work is required to identify availability of the data. Proxy measures may be developed.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Central Bedfordshire will use the national metric.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

For all of the metrics used to measure the progress of our Better Care Fund plans, we have looked at historic local performance to establish trends. We have then applied the recommendations of the ready reckoner to establish the necessary impact our programmes need to exert in order to be statistically significant. We have also studied what has been achieved elsewhere to ensure that the expected outcomes of our BCF plans are credible. This is important to generate commitment to the programmes from across the local health

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

This plan covers only the Central Bedfordshire Health and Wellbeing Board.

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Outcomes and metrics

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	602.9	N/A	518.4
	Numerator	256		236
	Denominator	42465		45525
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	0.74	N/A	0.84
	Numerator	77		87
	Denominator	104		104
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	140.3	134.8	136.5
	Numerator	288	254	258
	Denominator	205296	208330	311310
		Apr - Nov 2013 (Average)	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	139.4	122.9	123.4
	Numerator	366	1 7	332
	Denominator	262512	266041	269580
		Apr - Sept 2013 (Average)	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		*(State time period and select no. of months)*	6 'A	*(State time period and select no. of months)*
Emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population	*Metric Value*	1364.1		1236.7
	Numerator	549		563
	Denominator	40275		45525
		Apr 11 - Mar 12	*(S 1 period and select no. of months)*	*Apr 13 -Mar 14*

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The Central Bedfordshire Council and Bedfordshire CCG Better Care Fund Plan

Our approach to Better Care Fund Planning

Central Bedfordshire Council and Bedfordshire CCG's Better Care Fund plan is based on accelerating our progress towards delivering the priorities and outcomes agreed by the Health and Wellbeing Board.

Central Bedfordshire Health and Wellbeing Board's overarching vision is well understood and set out in the Joint Health and Wellbeing Strategy. Our vision is to ensure that Central Bedfordshire is "a place where everyone can enjoy a healthy, safe, and fulfilling life" and that the area is "recognised for its outstanding and sustainable quality of life". The strategy makes clear that this will be achieved by "working in partnership with our communities and residents to improve the opportunities open to them to improve their health and wellbeing".

Our Better Care Fund plan sets out a shared vision for health and social care in Central Bedfordshire, rooted in a locality-based delivery model. It describes the agreed strategic approach based on four priority programmes for delivering integrated care at scale and pace, and therefore achieving the key outcomes expected by the Health and Wellbeing Board and the people of Central Bedfordshire.

We recognise the challenges in delivering the Better Care Fund programme in the context of a rapidly growing and ageing population, located in a predominantly rural area across the catchment areas of seven acute hospitals – none of which is within the Central Bedfordshire Council area. The number of residents is set to increase from 255,000 to 287,000 by 2021. A particular challenge will be the increase of older residents, with the number of over 65s rising by 35% over this period, from 40,275 to 54,420, and the proportion of over-85s increasing by 53%, from 4,770 to 7,317. Our four programmes of work are targeted at transforming our services jointly to contend with this increase in demand and complexity, as well as current pressures on our social care services and emerging through the emerging Care Bill. Our plan sets out the immediate actions we will take to deliver longer term sustainability in the system as a whole.

All of this works well because in Central Bedfordshire there are four existing and well-defined population centres based around the towns of Dunstable/Houghton Regis, Leighton Buzzard/Linslade, Ampthill/Flitwick, and Biggleswade/Sandy. These population centres form the basis of well established localities (Chiltern Vale, Leighton Buzzard, West Mid Beds and Ivel Valley) that are to be the focus of developments in health and social care. The Council's older peoples and disabilities services are coterminous with the localities and we have already established integrated health and social care locality arrangements in the Chiltern Vale area and plan to expand this approach across the locality and then the rest of Central Bedfordshire, with a particular focus on improving

outcomes for older people. Locality arrangements are central to responding to local demographic pressures and the increasing complexity of existing pathways within health and social care.

We will build on our existing locality structure to address each step of the care pathway, from prevention and early intervention right through to integrated pathways and support for people at home. In doing so, we will address multiple issues, including support for carers, intervening at the right point to maintain independence, physical health and mental wellbeing, and using housing options and equipment to ensure that we respond effectively to the increasing volumes and complexity of older people's conditions, such as dementia, heart disease, stroke, associated dependency, and social isolation.

The Better Care Fund Programme will create a minimum pooled fund of £15.144m in 2015/16 to support the delivery of integrated care to which it is proposed that additional funding of £146k of CCG and £3.417m of Adult Social Care resource will be committed making a total of £18.707m. Consideration will be given to expanding this pooled resource particularly in the context of Continuing Health Care Funding.

In setting out the four priority programmes below, we recognise the importance of shifting resources from hospital settings to more community-focussed care to deliver improved health and care experiences as well as more effective use of resources:

1. **Reshaping the model for prevention and early intervention** – through an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health.
2. **Supporting people with long term conditions through multi-disciplinary working** – focussing services around general practice in locality networks and helping people to manage their own conditions in the community.
3. **Expanding the range of services that support older people with frailty and disabilities** – integrating the range of housing, mobility, carers and other services that wrap around older people with specific conditions and issues and helping to manage new demand including through the Care Bill.
4. **Restructuring integrated care pathways for those with urgent care needs** – ensuring that these are seamless, clear, and efficient to help deliver the clinical shift required to move care away from acute settings, where appropriate, as well as building future resilience for emerging statutory requirements on the Council.

The Better Care Fund Plan in Central Bedfordshire will be ambitious for its residents taking forward a shared approach which builds on work already completed including the Community Bed Review, Joint Health and Well-being Strategy, Integrated Care Pioneer bid, South Bedfordshire Demonstrator project and investment in Prevention Services. It is intended that this approach can be applied across all customer groups including children and young people.

The Better Care Fund Plan will also be informed by the Review of Health Services in Bedfordshire and Milton Keynes. This review will also inform the future commissioning of community services in the delivery of out of hospital care.

The Central Bedfordshire Better Care Fund Plan includes a draft action plan for delivering on the programmes of work identified and benefits modelling to ensure successful delivery of the vision. The benefits modelling takes account of:

- Demographic demand and increasing number of people requiring services through early intervention and prevention;
- The need for productivity and efficiency savings; and

- The impact on services of redesign and re-specification.

This work is underpinned by strong governance and accountability arrangements, exercised through a robust performance framework overseen by the Health and Wellbeing Board.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

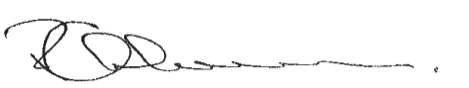
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

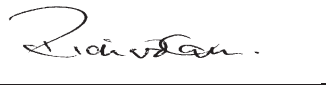
1) PLAN DETAILS

a) Summary of Plan

Local Authority	Central Bedfordshire Council
Clinical Commissioning Group	Bedfordshire Clinical Commissioning Group
Boundary Differences	Bedfordshire CCG's boundaries are coterminous with Central Bedfordshire and Bedford Borough Councils.
Date agreed at Health and Well-Being Board:	**3 April 2014**
Date submitted:	**28 March 2014**
Minimum required value of ITF pooled budget: 2014/15	**£3.821m**
2015/16	**£15.144m**
Total agreed value of pooled budget: 2014/15	**£3.821m**
2015/16	**£18. 707m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Paul Hassan
Position	Accountable Officer / Chief Clinical Officer Bedfordshire Clinical Commissioning Group
Date	3 April 2014

Signed on behalf of the Council	
By	Richard Carr
Position	Chief Executive Central Bedfordshire Council
Date	3 April 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Mrs Tricia Turner, MBE Central Bedfordshire Health and Wellbeing Board
Date	3 April 2014

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group have well established mechanisms for provider engagement. Regular meetings and forums take place across the Council and NHS and increasingly these are joint and part of integrated governance arrangements. Provider forums take place across commissioners and client groups. Open days bring together providers to discuss emerging trends, strategic and financial issues, and commissioning intentions. In adult social care, quarterly provider forums take place. Large events bring together providers across the area. We recognise the challenge of working with 7 different Acute Hospital Providers to ensure equity of access to care and support services for vulnerable older people.

More specific engagement activity is linked to clearly signposted commissioning changes and takes place focussed on client groups (such as older people), services (such as home care) and sectors (including targeted voluntary sector engagement). These forums and meetings have been fundamental to the development of the current Joint Strategic Needs Assessment (JSNA), the Joint Health and Wellbeing Strategy (JHWS), Central Bedfordshire's Adult Social Care Market Position Statement (MPS), Bedfordshire CCG's Plan for Patients, and other strategic planning documents. Forums are followed up with other regular communication; including newsletters, further information, and consultation. Open communication is maintained throughout as a key part of the commissioning role. One-to-one leadership meetings with the acute providers and other key providers also take place.

Our Better Care Fund plan reflects the broad understanding of the key issues, vision, and ambitions for the population, developed with our providers and has been influenced by detailed pieces of work focussed on specific issues. These include the recent review of community beds provision in January 2013, the Central Bedfordshire Pioneer Bid for integrated care submitted in June 2013, the Ageing Well programme, the Joint Commissioning Strategy for Improving Outcomes for Frail Older People (2012-15), and our Voluntary, Community and Social Enterprise Commissioning Pilot in 2013.Specifically on the Better Care Fund Plan, we have shared our plan with key providers and stakeholders with specific workshops on developing integrated services with the Luton and Dunstable NHS Hospital Foundation Trust on 30 January. This is in addition to the

wider contract negotiations led by Bedfordshire CCG and the review of sustainable health services taking place across Bedfordshire and Milton Keynes. Already we have identified key points from acute providers such as the need for detailed modelling to take place to understand patient flows and different models of care for increasing complexity of need.

We have also undertaken specific and targeted engagement with community-based health and social care providers. This includes engagement on elements of the plan with our locality GP networks in January 2014 and our Older People's Delivery Partnership in February 2014. Providers remain integral to all of these established governance groups and consultative forums. In the context of the large number of acute hospitals providing urgent care services to our population, a process has been put in place to ensure that there is good knowledge of the Better Care Fund change programme being led by the host health and social care commissioners of those hospitals. Given the national requirements for the Better Care Fund process it is anticipated that neighbouring systems will be taking forward very similar programmes but clearly co-ordination will be very important. It is also anticipated that locality partnerships will play a lead role in liaising with their catchment area hospitals.

We have continued to engage with our providers across health and social care services as we finalised the Better Care Fund plan and will continue to do so to monitor the risks and consequential impact of the changes proposed in our plan. . This will ensure that the our plan continues to have broad ownership and is deliverable. Further joint events with providers in the community and voluntary sector designed to enable engagement on plans for community services, are planned as part of our overall communication and engagement strategy for our Better Care Fund Plan. We will also continue to use existing forums and meetings to share and discuss the plans with the wider workforce and other key stakeholders.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Across Central Bedfordshire, partnerships are central to how we ensure that our plans for commissioning health and social care are shaped by the views, ideas, and experiences of patients, service users, and local communities. Our main means of engagement has been through the development of the JSNA, JHWS, and the strategic planning processes for both Bedfordshire CCG and Central Bedfordshire Council. The outcomes of these events have directly shaped both the Bedfordshire Plan for Patients and this Better Care Fund submission.

In June 2013, we held deliberative events with patients, carers and the general public to listen and understand the views of our local communities and organisations in key areas, including the vision for healthcare services, what needs to happen immediately, and the key priorities to consider when developing health and social care services. The outcomes of these events have helped to shape the Bedfordshire Plan for Patients and are helping to shape the emerging Better Care Fund Plan for Central Bedfordshire. A report on these deliberative events can be accessed from this webpage:
https://www.bedfordshireccg.nhs.uk/page/?id=3713

We have used our Healthier Communities and Older People Partnership Board to engage service users, carers, and user-led organisations on plans for how care and support should be provided for older people (and particularly the frail elderly). We have adopted a principle of co-production with all key stakeholders in redesigning and commissioning care and support.

The draft Better Care Fund plan reflects the output and findings from the various engagement activities, all of which are helping to influence and shape the priorities for health and care.

We will continue to share and discuss plans with service users in existing forums and planned events. A robust communication and engagement plan is being produced for our wider integration agenda. We will continue to have meaningful engagement with service users and will work with Healthwatch Central Bedfordshire to undertake more broad-based engagement on the Better Care Fund plan before final submission. We have published information about the BCF on the Council and CCG websites and will continue to work with Healthwatch Central Bedfordshire to engage with patients, service users and the public at large to receive comments on the draft plan before final submission in April.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or Information title	**Synopsis and links**
Joint Health and Wellbeing Strategy	The JHWS outlines our vision for improving health and wellbeing and reducing health inequalities in Central Bedfordshire. Informed by the JSNA, we have identified three cross-cutting priorities where we want to make progress fastest: • Improved outcomes for those who are vulnerable; • Early intervention and prevention; and • Improved mental health and wellbeing. These are underpinned by nine priority work programmes all of which have indicators to measure our progress. http://www.centralbedfordshire.gov.uk/modgov/documents/s39990/CBC%20HWB%20Strategy%20Final.pdf
Central Bedfordshire Joint Strategic Assessment (JSNA)	The JSNA brings together what we know about the health and wellbeing of the people living in Central Bedfordshire. http://www.centralbedfordshire.gov.uk/health-and-social-care/jsna/default.aspx Executive Summary - 2013 http://www.centralbedfordshire.gov.uk/Images/CBC%20JSNA%20Exec%20Summary%202013_tcm6-32238.pdf#False
Bedfordshire Plan for Patients 2014/15 to 2018/19	https://www.bedfordshireccg.nhs.uk/page/?id=3950

Central Bedfordshire's Vision for Integrated Health and Social Care – Pioneer Bid	http://www.centralbedfordshire.gov.uk/modgov/documents/s44907/item%207%20EXPRESSIONS%20OF%20INTEREST%20FOR%20HEALTH%20AND%20SOCIAL%20CARE%20INTEGRATION%20appendix%201.pdf
Review of Community Bed Provision in Central Bedfordshire Recommendations for Improvement – January 2014	http://www.centralbedfordshire.gov.uk/modgov/documents/b5188/Item%2010%20Community%20Bed%20Review%20Monday%2010-Jun-2013%2010.00%20SOCIAL%20CARE%20HEALTH%20HOUSING%20OVERVIEW%20SC.pdf?T=9
Market Position Statement	The Market Position Statement brings together, in a single document, intelligence from the Joint Strategic Needs Analysis (JSNA), our commissioning strategies, and the preferences of different service user groups, including those who fund their own care, to help shape the future of the care and support market. It suggests some of the necessary changes and innovation required to design and deliver services in the future. Providers of adult social care and housing-related support services can learn about Council's intentions as a purchaser of services and its vision for how services might respond to the personalisation of adult social care and support. http://www.centralbedfordshire.gov.uk/Images/121213MarketPositionStatementweb_tcm6-37596.pdf#False
Improving Outcomes for Older People in Central Bedfordshire Joint Commissioning Strategy 2011 – 2014	This is Central Bedfordshire's first strategy for older people. The strategy addresses the care and support needs of older people and also reflects the views of older people locally. It outlines the main challenges, priorities, and commissioning intentions for health and care of older people in Central Bedfordshire over the next three years. It also sets out the intentions for joint commissioning and an integrated approach to the delivery of services for older people, focusing on establishing care and support priorities and opportunities for a more joined-up approach to achieving better service outcomes. http://www.centralbedfordshire.gov.uk/Images/OlderPeopleJointCommissioningStrategyv5%20-260112_tcm6-28420.pdf#False
Healthier Communities and Older People Partnership Board	The Healthier Communities and Older People Partnership Board brings together representatives from organisations across the across the area to help deliver the health and wellbeing agenda and improve quality of life. http://www.centralbedfordshire.gov.uk/health-and-social-care/adult-care/healthier-communities-older-people/hcop-board.aspx

Joint Strategic Approach to Prevention and Early Intervention across Central Bedfordshire	Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group believe that 'Prevention is never too early and never too late'. Our vision for prevention is one that promotes people's independence and wellbeing so that they can live a full and healthy life. http://www.centralbedfordshire.gov.uk/health-and-social-care/prevention/prevention.aspx
Joint Commissioning Strategy for Mental Health Services for Adults & Older People in Central Bedfordshire 2011–2014	The aim is to commission services which promote good mental health and focus on achieving positive outcomes for the individuals who use them. We will fully engage with the Personalisation Agenda and support individuals to identify opportunities for their own care. http://www.centralbedfordshire.gov.uk/Images/27102011AmendedJointCommiStratrAdultsOPMHandWBSvcsinCB_tcm6-28423.pdf

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

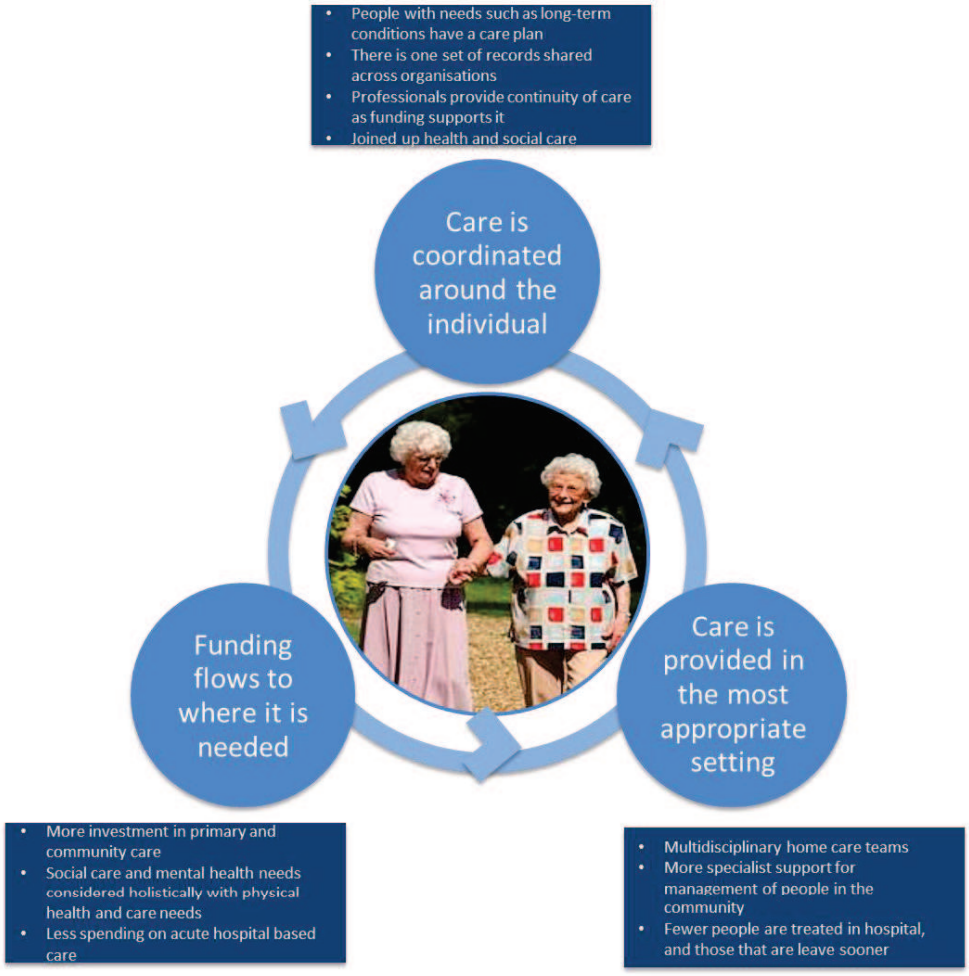
- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Vision for Health and Social Care Services

Central to our vision for health and social care is prevention and early intervention, delivering the right support in the right place at the right time, underpinned by the following principles for integrated care:

- Care coordinated around the individual;
- Care provided in the most appropriate setting; and
- Funding flowing to where it is needed.

These principles are reflected in the diagram below.

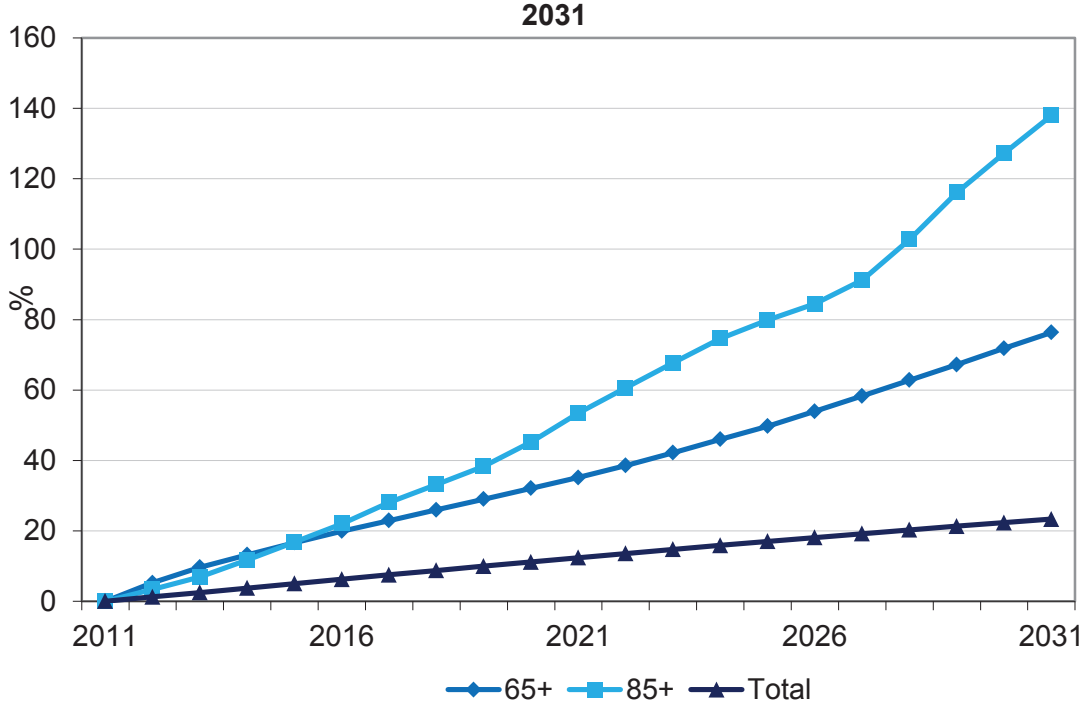


This will require health and care commissioners and providers to work together in a fully integrated way to meet the needs of the population, acknowledging that integration can improve the experience and outcome for the individual as well as improving the efficiency with which treatment and care is delivered.

Responding to the needs of a growing and ageing population

The case for integrated care is reinforced by the need to develop whole-system working to respond to the health and care challenges arising from an ageing population and increases in the numbers of people with long-term conditions. National and local evidence indicates that significant benefits are gained when organisations work together to co-ordinate care both for individuals and for populations. Central Bedfordshire is a desirable place to live and one of the consequences of this is a rapidly growing population. As the graph below shows, the overall population is expected to grow by over 12% between 2011 and 2021 but the number of older people aged 85 and over will grow by 138% over the same period.

Percentage increase in Central Bedfordshire population between 2011 and 2031



Breakdown of Population by Older Age Group

	2011	2016	2021	2026	2031	% change 2011-2031
65-69	12,682	15,603	14,495	16,870	19,531	54.0%
70-74	9,482	11,947	14,745	13,775	16,066	69.4%
75-79	7,841	8,493	10,808	13,418	12,628	61.1%
80-84	5,500	6,429	7,055	9,137	11,438	108.0%
85-89	3,196	3,757	4,585	5,125	6,820	113.4%
90+	1,574	2,062	2,732	3,674	4,529	187.7%
65+	40,275	48,291	54,420	61,999	71,012	76.3%
Total	255,644	271,640	287,288	301,977	315,329	23.3%

In some of the more deprived areas, over 30% of older people are living in poverty and over half live in rural settings. These pressures combine and generate a commissioning landscape that is constantly evolving, buoyed by high levels of inward migration, a mixed picture of deprivation, the inaccessibility of some residents and communities because of

their rurality, and variable quality in our housing stock. Associated with this increase in population, we have anticipated increasing demand for health and social care services.

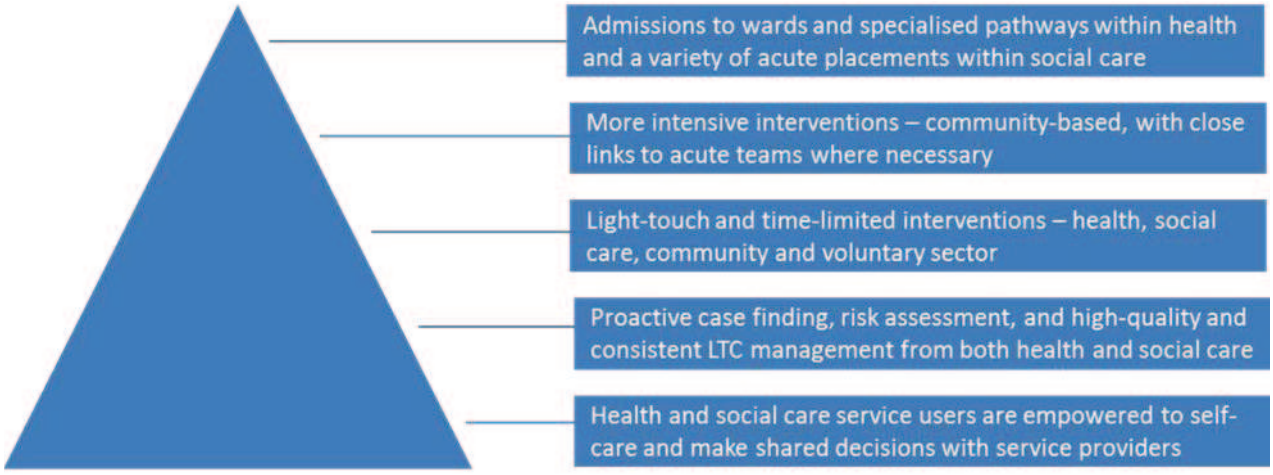
Key factors that influence potential changes in demand for health and social care in people aged 65 and over living in Central Bedfordshire:

	2011	2015	2020	2025	2030
People living with dementia	2,634	3,031	3,677	4,516	5,440
		15%	40%	71%	107%
People living with a limiting long term conditions	17,288	20,098	23,061	26,620	30,528
		16%	33%	54%	77%
People unable to manage at least one personal care task	13,131	15,077	17,578	20,648	23,936
		15%	25%	57%	82%
People unable to manage at least one domestic care task	16,010	18,379	21,530	25,294	29,240
		15%	34%	58%	83%

Since 2010, the prevalence of depression in those over 65 in Central Bedfordshire is estimated to have risen by 15%. Furthermore, approximately one third of older people with drinking problems develop them in later life and it is estimated that 1 in 6 older men and 1 in 15 older women are likely to be drinking enough to harm themselves. Social isolation is a causal factor linked to depression and alcohol misuse; higher levels of social isolation are characteristic of rural communities such as for many in Central Bedfordshire. Failure to tackle alcohol misuse in older people may contribute to alcohol related admissions. End of Life care and ensuring that our residents are able to die at home remains priority for us.

Model for Integrated Care

The Council and Clinical Commissioning Group have developed a joint overall model for integrated care. Our agreed model, which is population- and risk-focussed, is as follows:

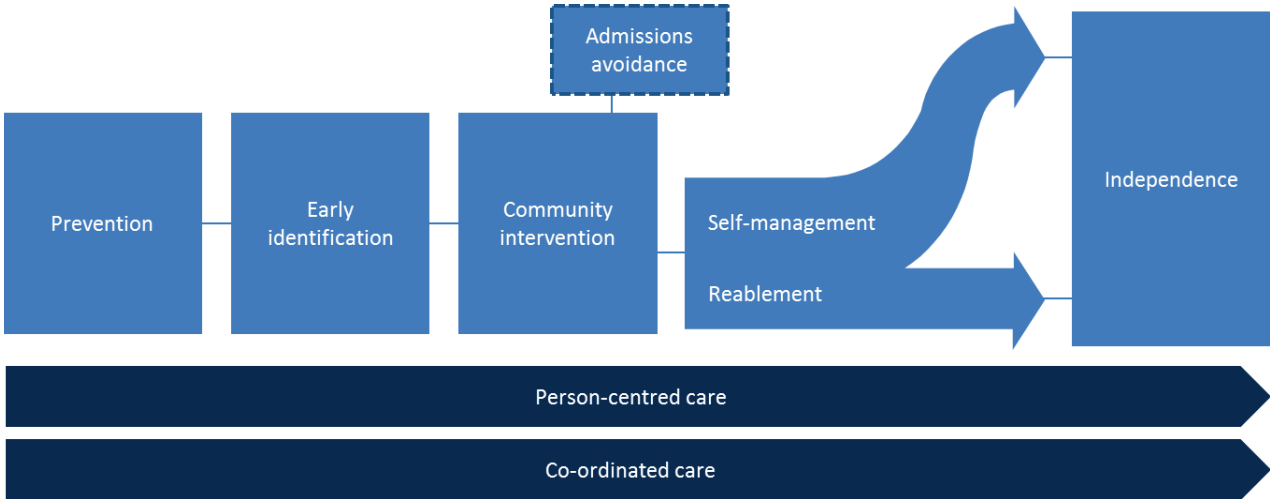


Delivering this vision for integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care. The Better Care Fund plan provides a substantial opportunity to bring resources together to address immediate pressures on services and establish a foundation for a much more integrated system of health and care delivered at pace. The agreed model of care (above) is underpinned by a new delivery framework for joint working across partners and client groups to deliver the full continuum of health and social care support. This includes prevention and early intervention, self-management, reablement and independence. For

mental health this will focus on closing the gap between access to physical and mental health services.

The key drivers underpinning the model are for person-centred and co-ordinated care. The model will be fully embedded over the next five years.

Delivery Framework for Integrated Care



The growing demand for health and care services experienced in recent years, taken together with the current delivery model, has led to a programme of change and diversion of investment which this plan will support. The scale of change is significant. For example, residential care represents £29m or 34% of net spend on adult social care in Central Bedfordshire – a level that is unsustainable. This will be more acute given the changes heralded by the Care Bill around the cap for people's contributions to their care costs. Shifting the balance of this care from institutional to personal support can be achieved through early intervention and prevention, the use of adaptations and technology, and better access to information and support for people to enable people to manage their own conditions and remain independent is the approach that has developed over the last 4 years. This provides a firm foundation to build upon.

Joint programmes to improve the integration of services have already started. In the Dunstable and Houghton Regis locality, for example, CBC and BCCG have made significant progress in the development of sub-acute care pathways for the frail elderly working across hospital, community, social care, and GP services, investing in and delivering real changes in the pattern of services. The focus of our BCF plan is older people, and especially older people experiencing frailty, and the changes we will deliver over the next five years are the types of changes we have started in the Dunstable and Houghton Regis locality.

Principal changes – 2014/15-2018/19

Together, these planned changes mean that over the next five years we will deliver the following programmes or changes, on which this plan is based:

1. **Reshaping the model for prevention and early intervention** – through an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health. This will ensure the most progressive, evidence-based prevention and early intervention programmes are available to our population.
2. **Supporting people with long-term conditions through multi-disciplinary working** – focussing services around general practice in locality networks and helping people to manage their own conditions in the community. This will ensure

robust and consistent arrangements are in place across Central Bedfordshire to both identify and organise effective support to those with long term conditions, particularly those with complex co-morbidities. This will include access to multi-disciplinary support and packages of care organised to maximise independence.

3. **Expanding the range of services that support older people with frailty and disabilities** – developing and integrating the range of housing, new technologies, mobility. This will ensure availability of services which wrap around older people with specific conditions to maintain their independence and remain in their own homes and in their communities for as long as it is safe for them to do so.
4. **Restructuring integrated care pathways for those with urgent care needs** – ensuring that these are seamless, clear and efficient to deliver the clinical shift required to move care away from acute settings, where appropriate.

Our proposed programmes are based on delivering sustainable changes which will build our capacity for the longer term, including requirements coming through the Care Bill. Overall, our approach will involve ensuring that those who would benefit most from person centred and co-ordinated care and support do so and reduce traditional over-reliance on the acute sector to meet their needs. Joint Urgent Care programmes have commenced the re-structuring of care pathways so that only patients who are acutely ill are treated in acute settings. This restructuring of sub-acute care pathways will enable a shift of resources to the community providing increased capacity, improving the experience of carers and users and the delivery of complex care including specialist services at the local level. The nature and scale of these changes is described in section 2C.

Role of Locality Partnerships

Building on a robust history of GP locality networking across Central Bedfordshire, we will establish multi-agency locality partnerships.

These partnerships will play a key role in the development of integrated services and will deliver multi-agency prevention programmes, joint risk stratification and case management, and the development of virtual single services across health and social care. These partnerships will involve GP practices, community health and social care services, hospital outreach services, patient representatives, and the voluntary sector.

To deliver this vision, we will develop integrated Health and social care hubs which will provide:

- A wider range of primary health services ;
- Accommodation for groups of practices who wish to co-locate under one roof;
- Improved access to GPs through extended hours, out of hours and walk-in services;
- A focus for management of more complex long term conditions including dementia care;
- Access to mental health care services; and
- Access to all out of hospital care services.

Supported by locality partnerships and integrated care hubs, general practice will have a vital role in profiling individuals who are at risk of hospital admission and working with community health and care services to reduce that risk through long-term condition management and home care support. Community health and social care teams will work together in an integrated way with single assessment processes and rapid responses to needs, focused on home care.

Patient and Service User Outcomes

These changes in the way services are organised will mean our population will:

- Have access to a wider range of support to prevent ill-health, with increased emphasis on early interventions supported by voluntary, community and long-term condition groups, enabling them to stay healthier for longer;
- Be supported to remain independent through integrated GP and community services delivered directly within their own home wherever it is possible to do so;
- Have access to a wider range of health and care services in the community that will help to avoid unnecessary hospital admission and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so;
- Have access to mental health services that are integrated with physical health and social care services, through primary, community and specialist teams.
- Have access to rehabilitations and reablement services that will avoid or minimise the need to enter into residential or nursing home care;
- Experience services that are person-centred, highly responsive and flexible, designed to deliver the outcomes important to the individual; and
- Benefit from stream-lined and integrated working with joint information systems.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

We developed the aims of our integrated care programme jointly in 2013. Engagement with our patients, users, carers, providers, and voluntary and community sector colleagues was a key part of this process.

In achieving our vision, the overall aims and objectives of the integrated system are to respond to new requirements and changes in legislation such as the Care Bill, as well as demographic changes and increases in complexity and to:

- Provide more proactive rather than reactive care;
- Develop care pathways focused on people rather than organisations;
- Apply local intelligence gathered from listening to the voice of the our local communities;
- Co-produce the support for individuals and their families to remain independent;
- Work with individuals and communities to use public services effectively and thus manage their own independence and maintain their own health better;
- Improve outcomes focused on maximising independence and improved experience of health and care services;
- Reduce the numbers of individuals admitted to hospital with urgent but sub-

acute care needs, with a consequent reduction in capacity in acute services;

- Reduce the number of people in long-term residential care; and
- Improve the support provided to family carers.

The BCF plan will have a strong performance management framework and clear targeting of benefits. This will underpin decision making, effective use of resources, and how we make clear judgements about progress and realigning resources where necessary.

The principal measures of our programme will be the national BCF metrics, which will monitor:

- Admissions to residential and care homes;
- The effectiveness of reablement, i.e. the proportion of people (65 and over) still at home 91 days after discharge from hospital into reablement/rehabilitation services;
- Delayed transfers of care;
- Avoidable emergency admissions; and
- Patient/service user experience.
- Local Metric - Injuries due to falls in people aged 65 and over

In addition, we will also use the following measures to assess our progress:

- Reductions in overall levels of urgent admissions of older people;
- Reductions in average length of stay, maximising stays of <48 hours;
- Reduction in excess bed days;
- Reductions in re-admissions to hospital within 30 days;
- Reductions in the rate of emergency admissions for the over-65s due to falls;
- Reduced hospital costs and increased investment in out-of-hospital care;
- Reduced proportion of budget spent on long-term residential and nursing care; and
- Improved accessibility and responsiveness of services.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

There are important opportunities to reshape services for older people in Central Bedfordshire, with a clear focus on those experiencing or likely to experience frailty. This requires a response to wider system issues, such as accommodation, adaptations, transport, and carers' support, which are important to making a step change in outcomes.

The redesigned care system across Central Bedfordshire will utilise national evidence as well as local experience from the South Bedfordshire Sub-Acute Care locality partnership demonstrator site. Through engagement with clinicians and a robust approach to

working in partnership, a sizeable reduction in acute activity has been achieved. This local evidence forms the basis for our modelling of benefits through this programme.

Four key programmes have been identified to deliver the overall plan. There are clear interdependencies between these programmes, which will need to be progressed in concert.

The four programmes are as follows:

- **Reshaping the model for prevention and early intervention** – through an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health. This will ensure the most progressive, evidence-based prevention and early intervention programmes are available to our population.

This programme will focus on preventing mental ill-health and the impact of disabilities. It will adopt an approach that moves away from assets and infrastructure to enhancing the skills and abilities of the individual to be independent, thereby reducing reliance on care services through an integrated range of support in:

- Primary prevention – providing whole-population advice on healthy lifestyles and mental wellbeing;
- Secondary prevention – identifying people at risk of poor health or social care outcomes and helping them manage that risk as well as possible; and
- Tertiary prevention – providing active support to those with established conditions or complex social care needs to minimise disability and deterioration and maximise their independence, choice and control.

Planned changes and key success factors:

- Utilise locality partnership arrangements as a mechanism for assessing and facilitating effective delivery of prevention programmes in each locality by September 2014. This will include initiatives for reducing social isolation and promoting social capital.
- Review opportunities for lifestyle hubs, incorporating nutrition advice, exercise and mental health promotion, in support of each locality by March 2015.
- Integrate lifestyle modification and support programmes into joint care plans on a phased basis from 2015.
- Develop comprehensive primary care mental health services that promote wellbeing and ensure that people are assessed and treated at the earliest point in their illness. This will include the promotion of screening tools and access to self-help materials.

A key measure of success for this will be through the social care related quality of life, with people feeling supported to manage their long-term conditions.

- **Supporting people with long-term conditions through multi-disciplinary working** – focussing services around general practice in locality networks and helping people to manage their own conditions in the community.

This will involve an integrated approach to the care and treatment of those with long-term conditions and frailty, including the development of practice case registers, effective multi-disciplinary team management of patients at high risk of admission, and effective coordination of care following discharge from hospital.

Planned changes and key success factors:

- Establish locality partnerships to implement integrated multi-disciplinary developments in long-term conditions management by September 2014.
- Ensure that all patients over the age of 75 have a named GP by June 2014.
- Review opportunities for a clinical development programme for GP Practice leads in older people's care in collaboration with hospital specialists.
- Increase support to practices to aid early assessment and diagnosis of dementia.
- Ensure that the introduction of risk stratification is consistent and establish robust practice case management registers with a minimum of 2% of practice adult population (over the age of 18) being proactively managed with personal care plans.
- Establish robust arrangements to ensure vulnerable patients have same-day access to practices.
- Establish robust arrangements for practices to offer immediate access to other professionals, including dedicated practice telephone lines.
- Review case registers on a monthly basis with particular focus to offer alternative management to those who have been admitted to acute care. Improving the quality of End of Life Care

Community Health and Social Care Support:

- Ensure lead professionals and locality care co-ordinators are in place.
- Integrate health and social care occupational therapy services to provide a single point of access.
- Deliver integrated intermediate rehabilitation and reablement support.
- Integrate personal health and personal care budgets within a single care package.
- Improve access to co-ordinated EOL care
- Enhance post diagnostic support services for people with dementia and their carers.
- **Expanding the range of services that support older people with frailty and disabilities** – integrating the range of housing, mobility, carers and other services that wrap around older people with specific conditions and issues.

This programme will:

- Meet the accommodation needs of older people through a range of housing types and the use of new technologies.
- Build on research evidence that extra care housing delivers improved health and well-being compared to residential care.
- Maximise the use of Mobility and Access to Transport.
- Reduce isolation and improve support to carers.

Planned changes and key success factors:

- Ensure there is sufficient capacity in a range of accommodation to reduce significantly the need for placements in residential care.
- Take forward the CBC Meeting Accommodation Needs of Older People (MANOP) programme, focused on the expansion of extra care housing.

- Implement housing-related prevention programmes, such as 'Warm Homes, Healthy People' and falls prevention.
- Ensure the full use of new technologies within housing schemes, such as telecare.
- Establish an integrated non-urgent transport programme to maximise independence and meet specific transport needs, such as visits to GP practices and hospital, day activities, shopping, and other social events.
- Support village care schemes as a key access to support with transport needs.
- Improve access to psychological therapy services
- Primary care identification of carers and their health and care supports assessed.
- **Restructuring integrated care pathways for those with urgent care needs** – ensuring that these are seamless, clear and efficient to deliver the clinical shift required to move care away from acute settings, where appropriate.

As a key focus of activity and investment, this programme will produce an updated care model for the sub-acute care of older people based upon national best practice and the South Beds Demonstrator site, ensuring person-centred care at all times. This programme will facilitate the deployment of this care model across Central Bedfordshire, at all times remaining sensitive to the needs of individual localities.

Planned changes and key success factors:

- Jointly monitor individuals at risk and deliver rapid case management responses at times of crisis, thereby avoiding hospital or residential home admission.
- Implement robust 24-hour out-of-hospital care services for those with urgent but sub-acute care needs, including rapid intervention/hospital at home care services and access to intermediate beds (step-up/down) accessed through locality health and social care navigators.
- Provide new dedicated telephone access for professionals to link with general practice.
- Implement community-based geriatric specialist services.
- Implement rapid assessment through consultant-led older people's assessment and liaison services treatment and early effective discharge from the hospital sector.
- Implement a model of mental health provision within acute hospitals to provide seamless mental health support to patients. Establish a single point of contact for access to an integrated community-based health and social care service closely aligned with GP practices.
- Establish health and social care navigators on a locality basis with responsibility for delivering joint packages of care in support of practices.
- An integrated approach to the commissioning and use of intermediate care beds following the 2013 Community Bed Review.

This Better Care Fund plan uses the evidence base from the JSNA and reflects the priorities set out in the Joint Health and Wellbeing Strategy, particularly in relation to frail older people. It is consistent with the CCG's emerging five-year strategic plan and reflects the commissioning intentions of both health and social services. This plan will continue to underpin the implementation of the Care Bill proposals for the transformation

of adult social care and the wider integration agenda.

We have already started work on the delivery framework through which we will translate the programmes described here into practical implementation. This will be expanded following the submission of this first draft through a series of joint sessions between the Council and the CCG, which will look at:

- The implementation plan, with clear next steps;
- Dependencies and issues across the components of the BCF scheme;
- Further prioritisation for delivering the plans at scale and pace;
- Communication and engagement plans for the working up of the second BCF submission and the programme implementation period; and
- Further development of the programme structure, including governance, communications, and design authority.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The developments described in this Better Care Fund plan will strengthen primary and community health and social care services to enable more patients with urgent care needs to be managed at home or close to home. Investment in these services will mean reduced reliance on the hospital sector for emergency care and an opportunity to re-invest a very significant element of the current hospital spend associated with the current level of admissions.

Cost of urgent care and savings targets

This scale of change is described in paragraph 18 of the NHSE Planning Guidance *Everyone Counts: Planning for Patients 2014/15 to 2018/19*: “The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality including by reducing hospital admissions. Hospital emergency activity will need to reduce by 15% and CCGs will need to make significant progress towards this in 2014/15.”

This clearly has important implications for the general hospitals serving the population of Central Bedfordshire.

The situation in the Central Bedfordshire health and care system is particularly complicated, with significant urgent admissions to seven general hospitals plus regular but modest flows to a number of others.

In summary, for Central Bedfordshire in 2012/13 the overall number of emergency admissions (spells) was 20,342 at a gross value of £42.268m. Within this total, there were 6,211 admissions of patients over the age of 75 with a gross value of £17.413m (source: MedeAnalytics)

To respond to NHSE guidance, the health and care system will need to re-structure care pathways in a way that enables 15% of £42.268m – i.e. £6.340m – to be released from hospital spending.

It is anticipated that the focus of changed patterns of care will be upon the sub-acute care of patients over 75. To release the bulk of the £6.340m from the current spend of £17.413m on this age group will require a reduction both in the number of patients admitted and lengths of stay.

Demonstrator Project

In this context, commissioners from BCCG and adult social care within CBC have a successful track record of engaging clinicians across all sectors in the co-design and delivery of new ways of treating patients. In 2012 almost £4m of NHS transformation funds and Adult Social Care reablement funds was deployed on a programme of community-based sub-acute care in South Bedfordshire to reduce hospital admissions and shorten lengths of stay. This project culminated in successful benefits and positive outcomes for patients, an increased proportion of whom were able to return to live independently in their homes. Senior hospital and community clinicians are encouraging the continuation of this programme into a second phase of development. This is described as a demonstrator project in this Better Care Fund plan.

This project in the south of Central Bedfordshire has already seen a 50% increase in the numbers treated on a short-stay basis at the Luton and Dunstable Hospital, moving from 20% of total in the base year (2011/12) to 32% in 2013/14.

Senior hospital clinicians have indicated that 50% short stays might be targeted with comprehensive geriatric assessment on arrival at hospital and early, effective discharge from A&E and assessment units to enhanced intermediate services. This scale of shift in hospital bed days, associated with higher levels of short stays of less than 48 hours and shorter stays for those staying over 48 hours, would cover the bulk of the cost of alternative community management.

Ivel Valley Locality

A proposal for integrated working for improved outcomes for frail older people is being developed in Ivel Valley as part of a wider system leadership programme. This will bring together a targeted prevention approach with social workers and community matrons around practices to enable proactive case management of older people. Ivel Valley residents look to two acute hospitals principally for their acute care needs – Bedford Hospital and The Lister, part of East and North Herts NHS Foundation Trust. Early engagement with these hospitals has identified good alignment of strategic ambition and highlighted key priorities that the BCF delivery plan in Central Bedfordshire will seek to address, from an acute perspective. This incudes

- Intermediate services which align acute services such as clinical navigation team operating hours with the rapid response team and the responsiveness, simplicity and flexibility of these services
- Discharge to assess – support within Central Bedfordshire for the move to discharge to assess models of care for patients requiring a CHC DST
- Case management – in line with the evidence base that this should be at the correct scale and with effective risk stratification to ensure that intensive proactive support is targeted effectively and does impact on acute admissions
- 7 day working – that plans to move to 7 day working across acute and community should mirror one-another in implementation timetable and capability
- Role of geriatricians – that further work will be undertaken to explore the

opportunities for geriatrician roles within Ivel Valley, the key areas where this will add value to the patient experience and how this might be provisioned
- EOL and Care Homes – to develop common approaches across counties to the management of patients as they approach the end of their lives to ensure more are supported to die in their usual place of residence
- Public engagement – to provide strong assurance to the public during the implementation of the BCF transformation and especially to consider social marketing techniques that address risk perception and the shift to community care as the gold standard for older people and those at EOL, rather than a historic association to acute care
- Workforce – that there are early opportunities to realign workforce as well as challenges such as dual running during transition periods and that these should be addressed as part of a whole system workforce plan
- Carers – to recognise the signs of carer fatigue and how alternatives to acute care can be made available to support them proactively
- Local BCF alignment – to co-ordinate the Central Bedfordshire BCF with those of neighbouring counties, who host acute providers, to enable the impact on acute providers of changes to community patterns of provision to be managed.

The locality integrated partnership approach and Programme Partners Meeting are seen as strong tools in continuing this active acute sector engagement and co-ordination of the BCF plan going forwards.

Role of Locality Partnerships

The Demonstrator Project in the south of Central Bedfordshire will continue during the course of the Better Care Fund plan and expanded through a partnership programmes rapidly rolled-out across Central Bedfordshire. These partnerships will focus both on localities and across hospital catchment areas. Commissioning managers from health and social care will liaise with neighbouring commissioners and acute services regarding similar programmes in the seven hospitals based outside Central Bedfordshire but for which Central Bedfordshire forms part of their catchment population.

All health and care systems have a similar agenda driven by the national Better Care Fund programme. So although many of the hospitals serving Central Bedfordshire are outside of the Bedfordshire system, we expect commissioners in Hertfordshire, Cambridgeshire, Milton Keynes, and Buckinghamshire to be taking forward aligned programmes. It is anticipated that the NHSE Local Area Team will support co-ordination of programmes across a wider area.

Locality partnerships in the four Central Bedfordshire localities will be key to organising alternative community management. As described in other sections of this plan, the patterns of care cannot be changed unless there is improved infrastructure and improved ways of working. Locality partnerships will be central to delivering the changes that will necessarily reflect individual locality's circumstances and needs.

Although the focus is very much on releasing funds from the hospital sector, improved ways of working should also achieve greater productivity in primary and community care services. Locality responses to the Better Care Fund plan are emerging. For example:

1. **Taking forward integrated, multi-disciplinary care for older people and higher risk patients**

West Mid Beds practices have already embarked on a programme to provide proactive, personalised care to people with complex health and social care needs and who may be at higher risk of being admitted to hospital and desire to proceed with an

integration of rapid response health & social care services which will potentially include elements of out of hours medical care, nursing care and social care.

2. Developing a future proof general practice business model for the locality

The practices will develop a business plan for collaborative working to advance as providers of care, to give them an appropriate platform and infrastructure for delivery over and above traditional GMS core services and to more effectively play a role in the integration of health & social care services. Practices are committed to retaining their current 'clinical delivery units' and patient registers, but recognise that collaborative working offers opportunities around:

- premises management and development
- sharing clinical expertise and delivering services more efficiently (e.g. locality clinics)
- extending working hours
- delivering rapid response services (e.g. home visits)supporting care homes.

3. Ensuring a future commissioning model which encourages and incentivises integration between services

Following the completion of the review of healthcare services in Bedfordshire and Milton Keynes and the subsequent re-commissioning of community services and out-of-hours services, the locality will work with other teams aligned to the BCF to develop commissioning models and service specifications which span care pathways, incentivise joint working between organisations and professionals, and are focused on improving health and social care outcomes for local people.

Programme Budgets, Provider Partnerships and Risks

Where plans are delivered on schedule and savings are realised, service delivery and quality will be improved and sustained. Where plans are not delivered on schedule and savings are not realised, there is likely to be high levels of unfunded activity at both of our acute providers. This may cause destabilisation to both providers and the CCG. In addition, this is likely to impact negatively on key performance indicators, including those in the NHS Constitution such as referral to treatment times and A&E waiting times.

To reduce the risk of financial pressures associated with pump-priming new services whilst reducing reliance on current patterns of care and costs, commissioners will seek to establish provider partnerships with agreed programme budgets supported by a manageable risk share agreements. These provider partnerships will include at a minimum the hospital sector, GP locality networks, community health, and adult social care. They will be charged with changing patterns of care in line with the Better Care Fund programme, perhaps utilising 'Alliance Specifications and Contracts' that set out the programme of change required. This will ensure a clear financial envelope is agreed within which the change programme can be taken forward.

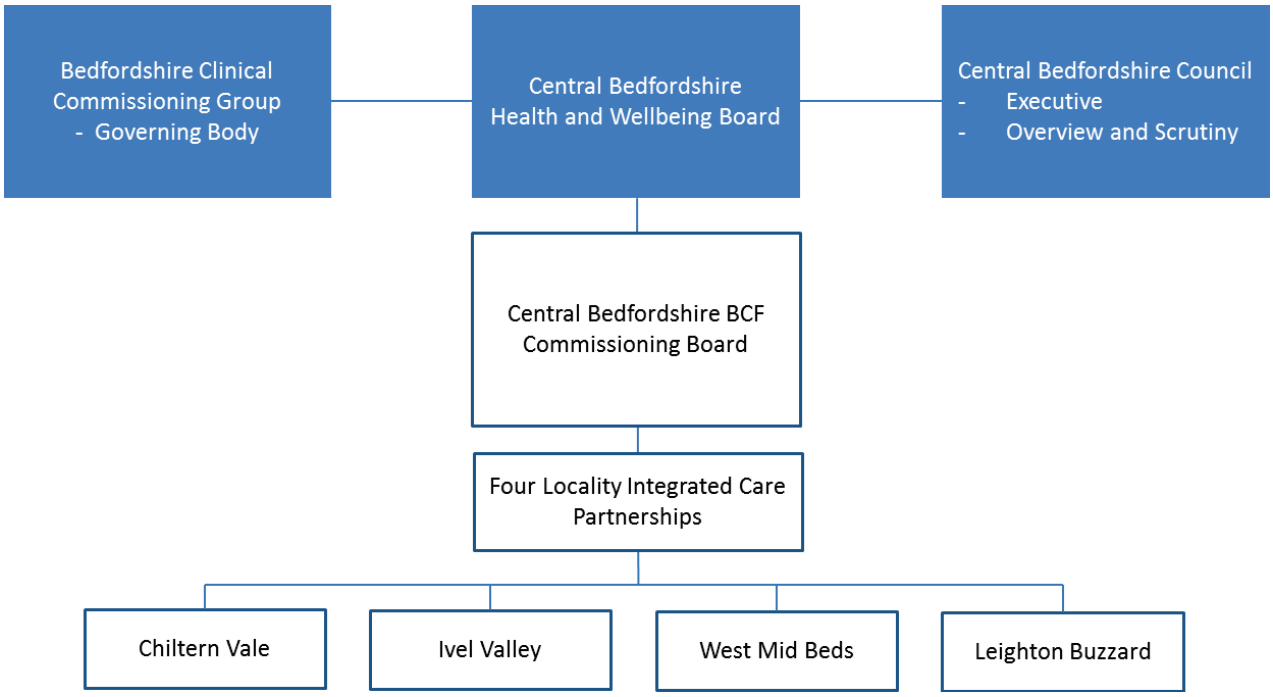
At the same time as the Demonstrator Project and other partnership projects gather pace, a review of sustainable services is being undertaken by Bedfordshire and Milton Keynes CCGs alongside Monitor, NHS England, and the NHS Trust Development Authority. This will result in a refinement of care models that will inform the re-

procurement of existing services across the acute and community sectors, based on the findings of the review.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The BCF plan and overall integration programme for Central Bedfordshire will be overseen by the Health and Wellbeing Board. A Chief Officer Group will be established to commission for integrated care (the BCF Commissioning Board), working closely with an Integrated Delivery Partnership. The HWB membership includes the executive member for Health, Social Care and Housing and the Chief Officers of the CCG and Council. The BCF Commissioning Board will have oversight of finance and performance and will report to the Health and Wellbeing Board. The performance framework will align equally to the Council and CCG performance monitoring processes. A programme management approach is being adopted. Local integrated partnerships will be established across Central Bedfordshire's four localities.



Our emphasis in devising these arrangements will be to mainstream BCF governance to the greatest extent possible in order to achieve the maximum alignment of the programmes involved into existing change programmes. The BCF governance arrangements will link into an Integrated Care Partnership, which is being developed.

3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services

Central Bedfordshire Council and the Bedfordshire Clinical Commissioning Group recognise the interdependence of health and social care in avoiding unnecessary hospital admissions, facilitating earlier discharges from hospital, avoiding institutional care for frail older people. We are committed to protect those services that enable people to have the best outcomes and spend the least time, if any, in acute/institutional care

The Council recognises the need to maintain current arrangements of providing social care support to adults and older people assessed as having moderate, critical, or substantial needs. Maintaining its moderate eligibility criteria is critical to preventing reliance on acute/institutional care. This will continue through reablement, additional funding for Disabled Facilities Grants/Minor works, targeted provision of community equipment, community alarms, and other telecare solutions, as well as investment in support to local communities to increase social capacity, such as, good neighbour/village care schemes.

In the second half of the plan, we will need to incorporate the requirements of the Care Bill for Social Care in respect of the national eligibility criteria, portable assessments along with the requirement to provide universal assessments for all those in need of care and for carers.

Please explain how local social care services will be protected within your plans

In the context of the reductions to local government funding, the Council's Medium Term Financial Plan assumes (to date) for adult social care pressures of £2.9m for 2014/15 and £3.8m for 2015/16 with efficiencies of £ 6.8m and £3.8m respectively

Our plans protect local social care services in four main ways:

- Funding for personal budgets/care packages, recognising unavoidable demand and demographic growth;
- Funding increased capacity to meet growing demand for reablement, telecare, and associated interventions to reduce increasing demand and costs;
- Funding increases in capacity/infrastructure to ensure more integrated case management and, crucially, to protect the supply of locally available services; and
- Building community capacity to enable support for people in their communities, for example through expansion of Village Care Schemes and Community Navigator type roles, as well as development of micro-enterprises.

Better Care fund will be deployed to fund the agreed on-going investment in 2014/15 and meet the unavoidable demographic/demand growth in 2015/16.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Our Plan is to further develop 24/7 services that are comprehensive across the four localities but recognise the need to flex the response based on differing needs. Currently there is a varied picture dependent upon the requirements of the seven Acute Hospitals outside of Central Bedfordshire.

The availability of robust intermediate services to prevent unnecessary admissions and to support early effective discharges in partnership with GPs and hospital consultants is fundamental to changing patterns of care. This has been described in a range of strategic documents.

Specifically, existing rapid intervention health and social care services operating in Central Bedfordshire are well placed to form the core of an enhanced service available to people in their own homes or care homes. To enable the service to achieve its full potential there needs to be:

- Consultant-level leadership ensuring that comprehensive geriatric assessment is provided to patients in all urgent care situations, i.e. in the home setting or within hospital A&E and assessment units;
- An integration of the existing community-based nursing and personal care services with Hospital at Home specialist outreach nursing from the hospital sector;
- Sufficient capacity and skills to enable the most progressive treatments to be available in out-of-hospital care settings on a 24/7 basis;
- Progressive working arrangements between hospital consultants and GPs to enable overall clinical responsibility for discharged patients to be passed at an appropriate stage of a patient's recovery;
- Access to an appropriate range of intermediate care/rehab beds which will be part of a joined up service;
- Align the 7 day service provision implementation plan with our providers wherever possible e.g. to ensure services are deployed in the community for acute discharge out of core hours.

It is likely that services need to be accessed through locality health and social care co-ordinators with direct links to practice named GPs and hospital physicians and consultant community geriatricians.

Health and social care commissioners will produce a new specification for such services. Partnership working between primary, hospital, community, and social care providers, as evident in the Demonstrator project, should enable the required service to be put in place readily. In particular, we will work with providers on staffing patterns to enable them respond to care requirements, especially at weekends.

As part of our programme plan we will develop a comprehensive cross-sector workforce strategy, modelling the impact of service changes on the system-wide workforce and addressing the cultural shift required to deliver new ways of working. An options and issues paper which will inform the response to 24/7 working has been produced.

We recognise that the response will require a partnership approach with providers and

with support from Health Education East of England and the Bedfordshire and Hertfordshire Workforce Partnership. We have also begun to identify key workforce implications with our providers as part of our early engagement activity on the Better Care Fund plan, for example highlighting the need for alignment of acute and community weekend core service hours to facilitate 24/7 hospital discharge.

The emerging workforce strategy will take account of the opportunities presented by the re-commissioning of community health services over the next 12 months and the early findings of the Strategic Review of Healthcare in Milton Keynes and Bedfordshire that is in progress.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

This is not the case at present but plans are in place to make it so – please see the next box.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by.

BCCG use the NHS number through using SystmOne. CBC will start using the NHS number as the primary identifier for correspondence by developing an interface with its Swift system, which is used in adult social care. We will be re-enforcing the collection of the NHS number as part of the Zero Based Review implementation and therefore will be routinely collecting the NHS number. We will also be reviewing options for developing common and shared systems across health and social care to facilitate data sharing.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The CCG is committed to the prescribed standards and the council will work towards adopting the standards.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldecott 2.

BCCG has completed the Information Governance toolkit and is compliant. It has also attained Stage 1 accredited Safe Haven status. All staff undertake annual IG training along with confidentiality clauses written into their contracts. Both organisations have designated Caldecott Guardians. Information sharing agreements are in place and the Council is currently working towards compliance with Caldecott 2 standards

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify
- what proportion of the adult population are identified as at high risk of hospital admission,
- what approach to risk stratification you have used to identify them, and
- what proportion of individuals at risk have a joint care plan and accountable professional.

As part of the development of integrated care, the multi-disciplinary approach within a primary care setting will jointly determine care needs and coordinate planned solutions with individuals and their carer, with the necessary professional support and resources flexed around personalised needs and preferences. As part of this, local people at a high risk of hospital admission have an agreed accountable lead professional and health and social care use a joint process to assess risk, plan care and allocate that lead professional. This approach will be under-pinned by IT-enabled information-sharing about individuals to achieve the key principles about care planning identified by National Voices.

These developments will build upon the joint work between targeted prevention social workers and practice matrons already well established in the Chiltern Vale / South Bedfordshire locality. The increasing use of MDTs will enhance the ability to carry out joint assessments that will offer a more integrated response and management of those who are vulnerable. MDTs will oversee a programme of risk stratification and targeted prevention as part of an integrated care pathway offer for older people.

This approach should help to reduce avoidable admissions and reliance on institutional forms of care.

Integrated assessment processes will continue, e.g. those associated with hospital discharge planning, as well as Continuing Health Care/Personal Health Budgets or intermediate care/reablement pathway, as part of a wider approach to integrated care. Improved intelligence-sharing within the MDT approach in integrated care will also enable health and social care to streamline and coordinate their own statutorily-required assessment, review and care planning arrangements (e.g. social care assessment within the framework of the Community Care Act).

The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and there is a commitment to fully implement the unplanned care directed enhanced service in 2014/15. This will require practices to risk profile and identify a minimum of 2% of their population over 18 to form a practice case register. Practices will work on a multidisciplinary basis to identify those at a high risk of admission and organise care packages to minimise that risk.

The current estimate is based on localities directly involved in the Demonstrator project. In Chiltern Vale, this equates to approximately 25% of patients over age of 75 that are at higher risk of admission based on Practice matron assessments. There will developments during 2014/15 to refine these figures.

General practice currently uses the MedeAnalytics tool to risk profile and stratify patients at high risk of admission.

We are currently reviewing the proportion of high risk patients needing an MDT approach

to assessment and case management and considering appointing locality health and social care co-ordinators. We are working through options for designated lead professionals with responsibilities for long-term condition management, planned home care coordination, urgent and unplanned home care, and care coordination following discharge.

The CCG will also work with practices to make sure that their plans are complementary to other initiatives through the Better Care Fund, as described in this document.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers.

The table below summarises the key strategic risks identified to date. This analysis of risks is being complemented by a full risks and mitigations log which is being produced in support of our Better Care Fund programme. We have already undertaken engagement with our broad programme team, including our localities, and established an initial risk and issues log for the programme.

Ref	Risk	Probability (%)	Impact	Risk rating & (RAG)	Mitigating Response Actions
01	As a result of failure to manage increasing demand for services through prevention and community services there is a risk that finance will not be released from the Acute Sector which could undermine CCG finances.	30-70%	Catastrophic	High	Council and CCG planning and savings work is predicated on a change of focus away from reactive to proactive interventions. Business plans and strategies across joint areas agreed or in process, with a greater focus on early intervention and support in the community. Development of the BCF plan across partnerships with shared priorities.
02	There is a risk that the need to deliver savings drives disinvestment and creates viability and sustainability issues for providers. There is a risk that the Acute Sector doesn't reduce capacity sufficiently to support the required shift in investment towards out of hospital care.	30-70% 30-70%	Major Catastrophic	Moderate High	Early and broad engagement with providers and organisations engaged in health and social care. Monitor of impact of savings plans on providers. Impact of plans on quality of service delivery monitored. Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered.
03	There is a risk of a failure to agree strategic redirection of resources to meet the objectives within the BCF plan, with resultant impact on commissioning and investment decisions, across health & social care.	30-70%	Catastrophic	High	Health & Wellbeing Board strategic partnership. Development of robust business cases to support investment and disinvestment decisions. Agreement of strategic priorities within the BCF plan. Further development of integrated service delivery projects with robust evidence base to measure success.
04	There is a risk that demand for crisis services (residential/ hospital services) will not reduce because of insufficient capacity of Community & primary services.	30-70%	Catastrophic	High	Early and broad engagement with community and primary care providers on the CCG and Council quality agenda.
05	There is a risk that due to lack of supply of Care	30-70%	Major	Moderate	Early and broad engagement with all providers linked to the Central

Ref	Risk	Probability (%)	Impact	Risk rating & (RAG)	Mitigating Response Actions
	Services especially in the north of Central Bedfordshire, the model as described cannot be implemented.				Bedfordshire health and care economy. Working with existing and potential new suppliers to maximise supply.
08	There is a risk that major Recommissioning will not be aligned with the implementation of the BCF.	5-30%	Major	Moderate	Development of the community health specifications in line with the ambition and requirements of BCF transformation (and the strategic review – see next line). Co-design of specifications with CBC where relevant to the BCF. Understanding of dependencies across the CHS procurement/ implementation and BCF implementation plans. Market stimulation activities with CHS providers for advanced awareness of BCF requirements.
09	There is a risk that the review of health services in Bedfordshire and Milton Keynes will not be aligned with BCF implementation.	30-70%	Major	Moderate	Close engagement with Monitor and the TDA as well as other local and national partners on emerging findings. Use of CCG and Council plans to influence the outcome of the review. Joint CCG and CBC agreement on adaptions required to BCF planning for alignment with the wider strategic review.
10	There is a risk that the BCF does not implement a 'whole system' approach resulting in negative financial and patient outcome consequences.	30-70%	Catastrophic	High	Work on jointly developed commissioning priorities and value based commissioning supports this. Accountability to H&WB board as well as internal governance boards. A performance framework which captures a more holistic view of people's journey through the care and support systems. A programme of culture shift to support education and change in practice across all partners.
11	Partner organisation staff do not receive sufficient support to manage the change with resultant impact on morale and service delivery.	30-70%	Catastrophic	High	Workforce strategies across partners need to take into account change requirements. High level strategic intentions need to translate into practical system, practice and process change support for staff delivering the change. Service and team plans reflect high level priorities.
12	Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs.	30-70%	Major	Moderate	Appropriate governance structures Provision of regular, timely and accurate information to support monitoring of services.

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